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Sub-theme 52: The Art of Making Do and the Science of Organizing in Future Health Care

Title:

Can French public hospitals make do with a dynamic and uncertain environment by developing inter-organizational restructuration strategies?

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Introduction

For a few years, public hospitals in France and in most of developed countries have had to deal with major issues. New legislations have recently been introduced, such as a prospective payment system (PPS: hospitals are reimbursed depending of the amount of services they provide), which aims at developing “business-like” management models, according to the New Public Management principles (Osborne & Gaebler 1994). Therefore, the dominant institutional logic in healthcare organizations is shifting, sometimes in very short periods of time, from “medical professionalism” to “business-like healthcare” (Reay & Hinings 2005). The PPS is a pro-competitive trigger, since hospitals are encouraged to develop their activity in order to generate more income by gaining market shares (Moisdon 2013).

What is more, public hospitals often have to cope with a major problem of medical workforce shortages (Kroezen et al. 2015), which threatens the existence of some activities in a lot of institutions, particularly in remote areas.

Furthermore, the evolution of medical practices, for instance the ambulatory turning point which consists in reducing, when possible, patient stay in hospitals to less than 24 hours, brings about a series of organizational concerns, as hospitals will be asked to cooperate with different stakeholders about healthcare pathways.

All in all, as in many developed countries, hospitals are pressurized into providing better care at an affordable cost, in a dynamic and uncertain environment, with potentially clashing demands.

In order to generate a transformation of the French public hospitals territory organization, and so as to meet the challenges mentioned above, the French government has implemented a set of tools aiming at fostering restructuration between neighbouring hospitals, thanks to cooperation and merger processes. For instance, a law voted in 2009 provided hospitals with the possibility to cooperate in Territory Hospital Communities.

Private clinics have been dramatically restructured in the past two decades amongst integrated networks, but public hospitals, which have been used to working relatively autonomously, have not followed this process to the same extent in France (Delas 2011). The results that the government was calling for have not been rather mixed so far. Given this relative failure, the State has decided to step up a gear by making cooperation mandatory. By the end of 2016, all hospitals will have to be part of a Territory Hospital Group. Territory organization of healthcare providers is regulated by Regional Health Agencies (RHA), whose mission is to promote restructuration leading to a better access to healthcare at an affordable cost.

The purpose of this paper is to contribute to the management literature about organizational change implementation in the case of inter-hospital reorganization, by analysing restructuring processes under way in France. The empirical material collected will be used to answer the following research questions:

1. To what extent are inter-hospital restructuring strategies an answer to uncertainty (such as the lack of medical resources) and pro-competitive triggers (e.g. the PPS) they have to cope with?
2. Is the transformation of the French public hospitals territory organisation led thanks to a regulated restructuration process, or is it the result of “making do” bottom-up strategies (sometimes partially unsuccessful) between hospitals?

The study was carried out thanks to two different case studies that analysed inter-organizational restructuration strategies in two French public hospital groups. Qualitative data was collected mainly by carrying out 30 semi-structured interviews with different stakeholders involved in the processes.

This paper shows that even though the necessity of performing inter-hospital restructuration is globally accepted by the different stakeholders, the conditions to implement this process raise a number of concerns. The role and missions of the regulatory institutions is not always clearly defined. Moreover, because of multiple factors that will be presented, it may be observed that inter-hospital restructuration is more often the result of “making do” bottom-up strategies, with uneven results, rather than that of a rational and wider regulation.

Literature review

Organizational change in Healthcare systems has been the focus of many research articles in the past few years. Several scientific authors account for the strong systemic inertia by pointing out professional group logics, which often are obstacles to the implementation of organizational change in healthcare, characterized by shifts in dominant institutional logics imposed by new legislations. For instance Reay & Hinings (2005) analyse the restructuration of the Health Care field in Alberta Canada, after a reform that promoted “business-like” management models at the expense of the “medical professionalism” logic that used to be dominant. Battilana & Casciaro (2012) explain the conditions that foster the adoption of change based on the examples of the transfer of clinical tasks from physicians to nurses and of policies challenging the dominance of hospitals over different healthcare providers, in the British National Health Service.

Inter-hospital restructuration (from cooperation to more radical change such as mergers) has been analysed in European countries, with divergent conclusion about their impact on reducing expenditure (Kristensen 2012, Bengt 2008). In France, the failure of public hospitals mergers in the 1990s encouraged the government to promote cooperation, as a softer restructuring process that is more easily accepted by stakeholders (Louazel 2013). However, corporatization of public healthcare providers observed in the past two decades (Ellwood 1996) which was implemented in order to foster performance, also produced undesired effects such as a difficulty to cooperate among providers, who turned out to be competitors. In order to make up for this, spheres of cooperation such as inter-hospital networks have been created, thus resulting in *coopetition* situations. This concept of *coopetition*, describing the coexistence of cooperative and competitive strategies, was developed by Nalebuff and Brandenburger (1996) and has been observed between

neighbouring hospitals (Baretta 2008) as well as between hospital networks (Peng & Bourne 2008).

Some research has been carried out in order to analyse the role of regulatory bodies on inter-hospital restructuring. For instance, Mur-Veeman et al. (1999) analysed the ineffective role of the Dutch government in implementing integrated care in local contexts. Reay et al. (2005) observed the new dominant role of Regional Health Agencies in restructuring healthcare in Alberta. The focus of this paper is to contribute to this topic by analysing, in the case of inter-hospital reorganization processes in France, the interplay between regulation bodies and hospital stakeholders.

Methodology

The empirical analysis is based on two case studies. Two groups of public hospitals, relatively advanced in terms of inter-organization reorganization, have been studied in two different French regions.

The first one is a Territory Hospital Community located in southern France, in a region unevenly populated on the territory, with remote hospital facing serious medical workforce shortages. This community has gathered since 2011 5 hospitals, 2 of which having merged since then.

The second one is a three-hospital group based in the densely populated periphery of a major city. These hospitals are managed by the same team and are working on a merger project in the short term.

Studying of both situations makes it possible to draw comparative elements with regard to the implementation of inter-hospital reorganization in two different contexts, characterized by different levels of integration (from inter-organizational cooperation to mergers). Both hospital groups are composed of a core hospital, relatively large and in a decent financial situation, and of periphery hospitals, smaller and more prone to economic difficulties and medical resources shortages.

The qualitative material collected is mainly based on 30 semi-structured interviews with different stakeholders involved in the inter-organizational restructuring processes: hospital managers, doctors, as well as members of the Regional Health Agencies.

In order to complete data collection, the analysis of internal documents dealing with this issue, and the observation of a working group about a project of hospital merger, have been carried out.

Data analysis helped the author to identify in the stakeholders' words the reasons mentioned to justify the necessity to perform inter-hospital restructuration, the hardships to this movement, as well as the different roles (regulation performed by the RHA as well as bottom-up initiatives) and points of view of the actors.

Results

Stakeholders see inter-hospital restructuring as a way of dealing with medical workforce shortages in some medical specialties (e.g. anaesthesia and surgery), and also as a means of building a stronger visibility and thus competitive position in market areas where private clinics are leaders. This is particularly interesting since hospital incomes directly depend on their activity and therefore on their market shares. Restructuring in both fields is mostly carried out in a soft way by mutualizing teams between the core hospital (relatively attractive and autonomous in terms of medical workforce) and periphery hospitals facing recruitment and retention concerns. This strategy brings about a better access to public healthcare on the territory, as well as the construction of medical networks from primary to secondary care between periphery hospitals and the core hospital. It also helps to achieve better quality services thanks to teamwork between young physicians and experienced professionals.

Thanks to the data collected, it can be inferred that inter-hospital restructuring in both situations results from “making do” bottom-up strategies, rather than top-down rational regulation, because of the three following factors:

1. The means of action used by hospital stakeholders coping with uncertain and dynamic environment are limited. For instance, investments granted by RHAs are restricted, and therefore cooperation or merger processes cannot always be implemented with the construction of a new building or with the purchase of a new expensive piece of equipment. Similarly, the lack of medical resources problem is only partially, locally and temporarily dealt with, thanks to teams mutualisation which sometimes appear to be stopgap measures: what is needed according to hospital managers is a national policy to regulate the distribution of physicians on the French territory, as well as

national improvements to the attractiveness of public hospitals (vs. private clinics): “*There is no clear vision of medical demography in the future in our region*” (Hospital manager).

2. Some stakeholders are reluctant to promote inter-hospital restructuring because they see this as a threat, as a potential loss of power. Hospital leaders in favour of change therefore have to *make do* with these positions that may slow down and reduce the scope of integration processes. For instance city mayors still play an important role in decision-making processes of this kind (Delas 2011). Medical communities in periphery hospitals may see restructuring and cooperative processes as threats to the independence of their institution (“*We do not want to be absorbed by the core hospital*”, doctor in a periphery hospital). Restructuring strategies, when carried out, are therefore defensive strategies, they are implemented because no alternative solution can be considered, with a certain level of distrust amongst stakeholders.
3. RHAs surprisingly enough do not always play a leading role in inter-hospital restructuring, although they do have some tools, such as the ability to impose the creation of a Territory Hospital Community. There turns out to be uncertainty about the definition of leading stakeholders supposed to run the restructuring project. Hospitals therefore also have to make do with this situation when implementing inter-organizational change: “*The RHA does not want to do the first step, to take the lead in the process. They are extremely unadventurous and want to let us decide how to sort things out*” (General Hospital Manager). This conclusion applies to both hospital groups analysed, for instance with regard to the perimeter definition of the hospitals to be involved in each reorganization process.

Discussion/Conclusion

In this paper we showed that inter-hospital restructuring strategies could be seen by stakeholders as positive ways to meet the challenges that French public hospitals are facing. However, these processes are often conducted with a bottom-up “making do” approach, with uncertainty with regard to the regulation role that RHAs should play and the autonomy that hospitals should have.

The implementation of Territory Hospital Groups in the near future in the whole country, by the end of 2016, is a milestone showing the government's willingness to speed up restructuring processes thanks to a stronger territory regulation led by the RHAs. It might nevertheless prove unsuccessful if some regulation policies on the national scale are not implemented, such as policies aiming at softening strong differences in the distribution of medical resources on the territory, as was the case in other countries such as Germany.

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